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By U.S. Mail and E-mail (Amy.Tibor@ct.gov)
Amy Tibor
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State of Connecticut
Office of Policy and Management
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Hartford, CT 06106-1379

Re: Comments to Mercer Report Regarding the Basic Health Program Option

Dear Ms. Tibor:

We are a broad coalition of health and consumer advocacy organizations which support adoption of a Basic Health Program ("BHP") for Connecticut. We submit these comments in response to the January 19, 2012 Health Exchange Planning Report submitted to the CT Health Insurance Exchange Board by its consultant, Mercer Health & Benefits. They are limited to Mercer's discussion of the BHP option outside of the Exchange for individuals with incomes above 133% of the federal poverty level (138% when the standard disregard is included) and below 200% of the poverty level. This discussion appears at pages 28-31 (executive summary) and 175-95 of the Mercer report.

I. Introduction

Mercer did not focus on the overall benefit to consumers, the state taxpayers and the health system in general of having all individuals in the state under age 65 and under 200% of the poverty level in one efficient, non-risk health care delivery system with continuity of care for all individuals whether they go above or below 133% of poverty. Nevertheless, Mercer did note that "building a BHP on a state's Medicaid infrastructure would allow states to cover low-income parents and children together in the same or similar plans and by the same provider networks." (page 175). The substantial benefits of a seamless Medicaid-like BHP administered along-side Medicaid with low overhead, efficiencies of scale, and joint administration through the same non-risk administrative services organization(s) (ASOs) cannot be overstated.

Mercer focuses on financial viability of CT adopting a BHP, including potentially with cost-sharing protections the same as Medicaid. As discussed below, while Mercer concludes

that a BHP is financially feasible, some of the discussion understates the financial benefits of the BHP option for the state. Mercer also does not mention some additional non-financial benefits to both consumers and the state from adopting a Medicaid-like BHP with a unitary delivery system for all non-elderly CT residents under 200% of poverty.

II. Financial Feasibility

Mercer states its charge to be examining "whether the BHP option can be implemented in the State of Connecticut (State) at existing Medicaid provider payment rates at little or no cost to the State (i.e., entirely funded by federal subsidies)." (page 175). After a lengthy discussion (pages 175-188), it concludes that "**under any scenario** based on the estimated subsidy and costs modeled in this analysis, **the result is that it would be financially feasible for Connecticut to offer a BHP option at Medicaid provider reimbursement levels with no costs to the State**." (page 188)(emphasis added).

In reaching this conclusion, Mercer first modeled cost sharing for individuals in the BHP as follows: for individuals below 150% of poverty, $10/month premiums and $5 office visit/$10 in-patient copays; for individuals at 150% to 200% of poverty, $20/month premiums and $10 office visit/$20 in-patient copays. With these cost-sharing requirements, Mercer found that the "net BHP cost to the State is $80 less than the estimated combined federal BHP subsidy…. This represents 22% of the $355 BHP cost, and could provide sufficient margin (assuming other assumptions hold) to operate a BHP without additional State funding from a purely financial perspective based on provider reimbursement differentials." (page 185)

But recognizing that the above seemingly modest cost-sharing still would cause many at these low income levels to opt not to participate in the BHP, Mercer also modeled cost-sharing to match Medicaid in CT, i.e., no premiums and no cost-sharing. For this scenario, Mercer concluded that the federal subsidies would provide "approximately 7% of the $405 BHP cost, and could conceivably provide sufficient margin (assuming all other assumptions hold) to operate a BHP without additional state funding." (page 187). Beyond this, Mercer concluded:

> "**This [no cost-sharing] Medicaid scenario provides the *best advantage to this low-income population, which would also have the best chance of maximizing enrollment*.** This scenario would both cover the greatest number of adults [since the higher cost-sharing would otherwise cause many to opt out] and result in the lowest morbidity level of the risk pool [since healthy young people would by and large participate]." (page 187)(emphasis added).

As Mercer also noted, while this scenario of a 7% margin "might appear to present the greatest risk to the State's budget," "this scenario will have the effect of generating the highest enrollment and the lowest level of morbidity in the risk pool, decreasing the likelihood that these unknown variables might deviate too far from assumptions." (page 188). Mercer clearly found a no cost-sharing BHP to be a realistic alternative for CT.

In reaching its conclusions, however, Mercer underestimated the savings from a BHP over (95% of) federal subsidies for enrollment with exchange insurance plans, in three important ways, involving erroneous assumptions about how much providing these enrollees with Medicaid-like services and cost-sharing protections in a BHP with provider rates the same as Medicaid would cost.

First, it assumed that the administrative cost for providing Medicaid-like services to the BHP group would be "15% (including profit, risk, contingency loading)" (pages 184, 185). No explanation is provided for this assumption but it appears to be based on the **maximum** medical loss ratio that is allowed for insurers contracting with a state to administer a BHP on a risk basis (page 176), as well as under the PPACA broadly for small group insurer-run plans. This is not unlike the administrative costs of the managed care organizations which contracted with the state under the Medicaid program until December 31, 2011. But the administrative costs under the **non-profit non-risk** ASO model now in effect in CT are much lower.

The long-standing administrative costs of the fee for service Medicaid program are about 5%, as reported by DSS's previous Medicaid director. However, as of January 1, 2012, we now have four non-risk ASOs (for behavioral health, dental, medical transportation and the non-profit CHNCT for all other medical services) contracting with DSS under Medicaid. On the high end, the ASOs' contracts total around $120 million/year. According to DSS's latest Comprehensive Financial Status Report (June of 2011), the total cost of CT Medicaid for the year July 2010 to June 2011 was estimated to be $4.465 billion. Accordingly, the additional administrative cost from these contracts is roughly another 2.7% ($120 million divided by $4.465 billion). So the total administrative costs for administering Medicaid on a non-risk basis are more like **8%**, not 15%.

Second, placing all Medicaid and BHP enrollees under one efficient administrative system with a unitary enrollment system, presumably through all the same ASOs, will avoid the administrative costs of someone around 133% of poverty churning between different systems and different sets of providers as their income fluctuates. Beyond this, just having everyone in one system will bring economies of scale, further driving down administrative costs. Accordingly, the overall administrative costs will be even lower than with an ASO for Medicaid alone.

Third, in moving to the ASO model, the Malloy Administration made clear that it assumes substantial savings from finally coordinating health care in a way that the risk-based MCOs always promised but rarely delivered on. Specifically, through the adoption of patient-centered medical homes which are paid modestly to coordinate all health care for their patients, a lot of unnecessary diagnosis and treatment, resulting from duplicative services or medical complications from conditions untreated at an earlier stage, can be avoided. This will save money overall compared with a traditional risk-based insurer-run system, as is contemplated for the exchange. Indeed, under the PPACA, a state opting for a BHP must contract either with

traditional MCOs **or** under a system with managed care-like attributes, and Mercer noted in its report that fee for service plus enhanced primary care case management (as is common under Medicaid programs and is essentially being adopted in CT statewide) would likely meet this requirement (page 176).

For all of these reasons, the 7% margin for the state taking on a BHP with no cost-sharing for BHP enrollees is a quite conservative estimate. The margin is likely much larger than that, sufficient to finance not only no cost-sharing but truly Medicaid-like benefits and services, so that health care delivery for individuals going above and below 133% of poverty will be seamless, as it will be for children and adults over 133% and below 200% in the same family.

III. Other Advantages of Adopting a Medicaid-Like BHP

As noted, Mercer's report does mention some of the benefits of adopting a BHP, including particularly a model which is Medicaid-like. It notes that **any** BHP will likely be more affordable for enrollees and, therefore, for the same income group, result in higher percentages of individuals joining the ranks of the insured compared with leaving them in the Exchange (page 183). Mercer estimates that with lower but still some cost-sharing under the BHP, 70% of BHP eligibles will participate, whereas only 50% of the same group would participate in the Exchange plans (pages 178, 192). It notes the potential benefits to the Exchange as well, from removing from its pool individuals who are projected to be costlier than other exchange participants, based on the strong correlation between income and health status (page 191).

Mercer also notes that any savings beyond what it costs to run the BHP must be plowed back into the program to improve it by lowering premiums and cost-sharing, expanding benefits or increasing provider rates (page 177). Given the concerns with provider access under Medicaid in part due to low reimbursement rates for some categories of providers, it will be important to prioritize provider rates with any excess savings. However, even if provider rates in the BHP are not increased over Medicaid rates (which, under the PPACA, must be increased to Medicare rates during 2013-2014 for primary care), the BHP population will be better served with a BHP with affordable care than through an unaffordable plan obtainable only through a risk-based Exchange insurer: according to Mercer, 50% of the same population would forego participation in the Exchange due to this unaffordability (page 192), meaning that for half of the population the provider reimbursements would not be low; they would be non-existent.

In addition, in the case of a Medicaid-like BHP, Mercer notes that this model will:

- Allow for parents and children to be in the same program with the same network of providers (which will also encourage parents to enroll and to follow through on appointments for their children)
- Allow for the state to leverage the same non-risk ASO structure for both Medicaid and BHP

The other advantages of a Medicaid-like BHP run through the same non-risk ASO system include:

- Protecting individuals with incomes fluctuating above and below 133% of poverty from disruptions in care and provider networks
- Protecting enrollees from overpayments of tax subsidies in the exchange, resulting from income fluctuations, and the consequent need to pay the money back at a time when they may be unable to do so
- Protecting this relatively low-income population from having services denied by a for-profit plan with a direct incentive to deny care, as under the exchange (this was a serious problem for Medicaid enrollees under the MCO system, one of the reasons CT just moved out of that system)
- Providing meaningful care management services through patient-centered medical homes (which also should serve to drive down costs)

Thank you for your attention to our comments.

Sincerely yours,

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